UNITED
NATIONS

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Economic and Social Council

Distr.
LIMITED

E/ICEF/1991/P/L.30
15 March 1991

ORIGINAL: ENGLISH

UNITED NATIONS CHILDREN'S FUND
Programme Committee
1991 session

FOR ACTION

RECOMMENDATION TO THE EXECUTIVE BOARD

Interregional programme of cooperation within the framework of the Bamako Initiative

The Executive Director recommends that the Executive Board approve special support to countries developing and testing approaches to the acceleration of primary health care within the framework of the Bamako Initiative for the period 1992-1994 in the amount of $9 million from general resources, subject to the availability of funds.

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INTRODUCTION

1. In 1988, the Executive Board approved an allocation of $2 million for the period 1988-1989 to cover the costs of initial planning and preparatory work to accelerate primary health care (PHC) and maternal and child health (MCH) in sub-Saharan Africa within the framework of the Bamako Initiative (decision 1988/3, E/ICEF/1988/13). In 1989, the Executive Board approved a further allocation for the Bamako Initiative of $10.5 million for the period 1988-1991 to cover in-country preparation and associated interregional support (decision 1989/15, E/ICEF/1989/12).

2. The Executive Board has consistently recognized the Bamako Initiative as crucial to the revitalization of health systems at community and peripheral levels and to the creation of suitable conditions for sustaining the vaccination coverage provided by the expanded programme on immunization (decisions 1988/3, 1989/15 and 1990/15 (E/ICEF/1990/13)). As the 1990s began, the Executive Board also recognized the Bamako Initiative as the key health strategy for achieving the goals of the 1990s.

3. As requested by the Executive Board, progress reports on the Bamako Initiative have been presented at its 1989 and 1990 sessions (E/ICEF/1989/L.3 and E/ICEF/1990/L.3), and a new report is being presented at the 1991 session (E/ICEF/1991/L.6). These reports outline the significant activities that have taken place in African countries, as well as in a few countries in other regions, as ministries of health and their partners have examined PHC and the situation of health care delivery systems and planned to strengthen and extend these systems under the Bamako Initiative.

4. Since 1988, when the Executive Board gave UNICEF the mandate to support ministries of health to develop specific proposals under the Bamako Initiative, a number of countries have integrated the Initiative within their respective UNICEF country programmes of assistance, including Benin, Kenya, Sierra Leone and Togo. Guinea and Nigeria are consolidating earlier country programme components and are presenting new recommendations to the 1991 Executive Board (E/ICEF/1991/P/L.8 and E/ICEF/1991/P/L.9, respectively). The Initiative is also prominent in the recommendations currently being presented for Cameroon (E/ICEF/1991/P/L.6), Equatorial Guinea (E/ICEF/1991/P/L.20), Ghana (E/ICEF/1991/P/L.7), Sao Tome and Principe (E/ICEF/1991/P/L.20) and Zambia (E/ICEF/1991/P/L.4). Burundi has prepared a significant proposal for supplementary funding (E/ICEF/1991/P/L.24) and Zaire is using the Initiative as the basis of important short-term action in its bridging operation (E/ICEF/1991/P/L.27). With support from ongoing country programmes of assistance, an additional 14 countries are reviewing their health strategies and shifting their orientations towards the Bamako Initiative.

5. Support to preparatory action in all these countries, either through direct allocations or technical assistance from interregional sources, has been instrumental in assessing and realigning health strategies in line with the Initiative. Improved country programme preparation in the health sector

has been one of the results of this support. Advocacy, exchanges of experience and training are key elements that have increased capacity, both in countries and in UNICEF offices, to tackle the issues and constraints inherent in the Initiative. In this context, the role of the Bamako Initiative Management Unit at UNICEF headquarters has been crucial in providing stimulus and ensuring necessary programme support. It will continue to fulfil this role, providing support for the consolidation of the Initiative in the countries mentioned above and for its adoption and implementation in the remaining countries of sub-Saharan Africa.

6. In addition, the Unit will continue to focus on key issues identified in the original presentation to the 1988 Executive Board (E/ICEF/1988/P/L.40) and elaborated upon in subsequent years. Operations research initiated in 1989 has already provided insight into health and health care problems, particularly regarding the existing financial cost of care to a household and the ways in which people make decisions on obtaining health care. In Sierra Leone, for example, self-treatment is the leading method of health care largely because of the cheaper cost. An expanded and more systematic approach to operations research will be one of the main areas of work of the Unit in 1991 and subsequent years. Support will also be provided to accelerate the development of more accurate country health profiles and of simple systems to monitor systematically progress towards a universally accessible and affordable health care delivery system.

I. COUNTRIES DEVELOPING PROGRAMMES WITHIN THE FRAMEWORK OF THE BAMAKO INITIATIVE

7. Since early 1988, the majority of countries in sub-Saharan Africa have focused attention on the Bamako Initiative. Of these, 12 are moving towards implementation on a significant scale and 15 others have initiated preparatory activities. In most cases, start-up activities were made possible because of allocations made directly to countries from the Bamako Initiative interregional programme.

8. Even in countries where services are being put back into operation under the auspices of the communities themselves, large percentages of the population still lack access to services because of geographical limitations. Services will be extended in the second stage of the Bamako Initiative once existing services have been adequately revitalized. Various options may exist, including additional infrastructure, outreach from present centres through mobile units, the extensive utilization of community health workers (CHWs) or a mix of these measures. No uniform model is expected in any given country; each district health system will have to determine the most cost-effective way of implementing the Initiative, depending on the local situation.

9. Therefore, support will be required not only for those countries still in the beginning stage of the Initiative, but also for those entering the critical second phase which is aimed at increasing access. During the period

1991-1994, it is envisaged that additional country allocations will be made in order:

(a) To enable countries to undertake preparatory and start-up action (especially in smaller countries in Africa with very limited resources for key studies), initial training to develop training and diagnostic or treatment manuals required to improve the quality of services;

(b) To promote continuing, specific country-to-country exchanges, which have already proved successful for learning the strengths and weaknesses of the programme and for improving programme planning and design;

(c) To test outreach alternatives in order to determine the most cost-effective means of extending services to unserved populations;

(d) To continue support to countries outside of Africa where specific interest has been shown in strengthening health care delivery systems according to the principles of the Bamako Initiative.

II. MONITORING

A. Country health situations

10. The deterioration of health services has been one of the most visible results of the economic crisis in Africa. It has been difficult to assess the actual situation of specific countries, however, because of the virtual lack of continuous and reliable data on health status and services. Regular collection of data has been sporadic, and what has been collected has usually been left unanalysed. Surveys have tended to be erratic and limited in focus, typically providing important data on specific diseases, but to a large extent ignoring the nature and quality of services provided.

11. In the last two years, Sierra Leone has been successful, through the Planning and Management Information Systems Unit of the Ministry of Health, in establishing extensive district health profiles in several of its 13 districts. Its eventual aim is to survey the entire country, district by district, thus establishing a nation-wide profile of the status of health and health services in the country. The survey results will then be updated regularly through the improved collection of basic statistics, including regular reporting activities and surveys.

12. Other countries have also begun to compile a similar set of district profiles. Nepal, like Sierra Leone, is concentrating on a health profile, beginning in five districts. Burundi is developing the methodology in one district with a view to using it in the rest of the country. Kenya, on the other hand, has opted for a broader socio-economic profile with health as one of the key elements of analysis. Within the Bamako Initiative's principle of decentralization to the district level, other countries are being encouraged to establish district profiles that allow for a more meaningful analysis of health status and services.

13. During 1991, increased emphasis will also be placed on introducing systematic monitoring of health and nutrition at the village level. The aim is to stimulate local analysis of the causes leading to death, illness or malnutrition among children and to facilitate monitoring of the evolution of local health and nutrition as actions are taken. Experience in a number of countries has shown that villages can undertake such monitoring using simple registers of vital events, which are also extremely useful within the overall peripheral health system.

14. Improved information management is a key element of the Bamako Initiative and support is envisaged for specific activities, including:

(a) The development of district health profiles in countries embarking on the Initiative;

(b) Follow-up surveys to detect key health changes as indicated by the regular reporting system;

(c) Testing, adaptation and progressive introduction of village-level monitoring of basic health and nutrition indicators.

B. Strengthening health services

15. Guinea is one of the first countries, in addition to Benin and Nigeria, where a monitoring system is being developed and tested for national-level data analysis specifically related to the Bamako Initiative and building on prior extensive data collection. In this system, there are two levels of data collection. Information on a number of key aspects of health delivery is collected at Bamako Initiative health centres and this data is also submitted to the central level for general analysis. Data collection has been tailored to monitor the main components of the Initiative.

16. Data is collected in the following areas:

(a) The utilization of health centres by the target population;

(b) Accessibility to health centres, based on a pre-determined standard that takes into account distance, proximity and commuting time;

(c) The availability of drugs, based on a determination of the number of health centres where drugs are out of stock during any given month;

(d) MCH services, including data on antenatal visits, child immunization, curative care, etc.;

(e) Community financing, with health centre records recording the total payments received for dispensed drugs and treatments. Many of the treatments delivered are based on standing orders that carry a specific cost, thus maintaining standard costs for these treatments. Data on expenditures from the revenue is also recorded, e.g., incentives paid to health workers and incidental and other maintenance costs for supplies, etc.;

(f) Equity, showing the numbers of exemptions to payment granted. The decision to allow or disallow exemptions is usually left to the discretion of subdistricts. The status of this decision is recorded in order to gauge cost-recovery levels.

17. The data collected at health centres is analysed by local committees and routinely aggregated and analysed again at the national level in order to monitor the overall performance of the health centres and health services delivery. Previously, analysis was done using log books and manual observations, but it was difficult to assess the performance trends of components from one monitoring period to the next without extensive and time-consuming exercises. Data on financial performance became complex and unmanageable without the aid of an automated system.

18. The Bamako Initiative Management Unit is, therefore, in the process of developing a "user-friendly", menu-driven database software in Guinea, customized specifically to the needs of the monitoring process. This software has been designed through dialogue between the Ministry of Health and the UNICEF office in Guinea.

19. The Guinea monitoring system has begun to demonstrate the usefulness of accurate, ongoing data in measuring service performance and indicating key trends in community utilization and financing. During 1991, it is envisaged that up to five additional countries will be supported with the design and introduction of field-level monitoring systems.

20. Thereafter, continued support would:

(a) Improve existing systems to allow for easier retrieval and analysis of key data, with particular emphasis on service performance;

(b) Modify existing systems in accordance with changing information needs;

(c) Introduce monitoring systems to all countries embarking on the Initiative so that key issues of concern are carefully followed;

(d) Facilitate evaluations through the use of ongoing data from the monitoring systems.

III. OPERATIONS RESEARCH

21. The Executive Board has requested consistently that operations research be given due recognition within the work of the Bamako Initiative. Action in the past year has accelerated in this particular area, including the collection and review of existing research relevant to the Initiative. Findings were consolidated in one of the papers UNICEF presented to the Conference on the Financing of Community Health Activities, held at Kinshasa in June 1990.

22. In order to address key concerns of the Initiative more adequately, including affordability of services, current health care practice, equity of access and drug utilization, specific research projects have been initiated. In Sierra Leone, a study on community health financing was carried out in four chiefdoms. The main part of the study involved 1,157 household interviews, from which data were collected on disease episodes, the choice of a health care provider, the amounts paid for consultation, medicines and travel and the sources of funds. Focused group discussions, interviews with health staff and routine data collection were also part of the overall study. One of the most significant findings relates to the association between the choice of health care and a household's ability to raise cash, which is done primarily by selling foodstuffs, borrowing from relatives or friends or begging. Taking into account the actual options available, self-treatment is eventually used, although if a government primary health unit is located in or near a village it is used extensively. Self-treatment because of affordability often means that using only a partial course of treatment will be followed. These findings are being fed back into the design of the Initiative in Sierra Leone so as to simplify the current pricing schedule, with suitable differentials to maximize revenues and at the same time avoiding deterring people from using facilities.

23. In Mauritania, research in nine villages has begun to indicate that considerable savings can be achieved simply by the presence in a village of a trained CHW with a sustained supply of essential drugs. In the past, one of the main household costs was for the transport of patients to health centres, which are often over 50 kilometres from many remote villages in the country. On average, the cost amounted to the equivalent of $20 per trip. In strengthening the network of CHWs as part of the start-up of the Bamako Initiative, at least half of these trips are being avoided, resulting in considerable financial benefit to households in the community.

24. During 1991, a more systematic approach to operations research is being established, involving greater links with universities in both Africa and industrialized countries and leading to the long-term study of key issues in several countries in Africa. Collaborative work programmes will be established, concentrating on community financing, essential drugs and their rational use, communications and education, community involvement, the ongoing situation of health workers and the quality of care provided. During successive years, support will be required:

(a) To continue research programmes in selected countries on selected issues of concern;

(b) To consolidate the linkage between universities and national institutions, working towards the better delivery of health care services;

(c) To improve the quality of research carried out in selected countries through systematic training and support for the design of protocols;

(d) To produce regular and high-quality technical articles on specific issues.

IV. INTERREGIONAL SUPPORT

25. The funding support approved by the Executive Board in 1988 and 1989 has enabled UNICEF, in collaboration with the World Health Organization (WHO), to lay the groundwork for the Initiative on a wide front across Africa and in a few interested countries in the region. This has included the formulation of implementation guidelines, technical meetings such as those held in Paris (March 1989), Freetown (September 1989) and Kinshasa (June 1990), as well as extensive consultations with other international, bilateral and non-governmental organizations. It has also included the development of programme and information materials for advocacy and to assist in country-level implementation. The funds allocated for interregional support have also facilitated the provision of intensive technical support for programme preparation.

26. As countries continue to develop their plans and programmes, UNICEF, along with WHO, will need to continue to respond in a flexible and dynamic manner. The Bamako Initiative Management Unit, together with the focal point at the WHO Regional Office for Africa at Brazzaville, will have to respond to specific requests for technical assistance and to act as a stimulus when required.

27. As detailed in the 1991 progress report, a core group of 12 countries is well into full-scale implementation, and an additional 15 have begun either preparatory action or in-depth assessments of their health care delivery systems. The latter group will continue to require intensive support for preparatory action in upcoming years, while the former will require ongoing technical assistance in key areas such as strategy and increasing access to health care. Significant continent-level support is envisaged at least through 1995 in order for health care systems to be developed in a manner allowing for long-term sustainability. In addition, some countries, both in and outside Africa and which have not yet begun an assessment period, will be supported in this process at the appropriate time.

28. Activities to be undertaken within the interregional support component will include:

(a) Social mobilization and advocacy, including conferences, workshops and the production of information materials;

(b) Participation in country programme assessments and preparations, including strategy planning and undertaking programme previews and reviews at regional and country levels;

(c) Field visits to provide direct support, document experience and develop further guidelines with case studies for PHC programme development in collaboration with WHO and other agencies;

(d) The provision of short-term staff to provide technical and operational assistance at global and regional levels;

(e) Continued staff development and training in the planning and management of health services delivery, including greater local control of resources and the vital role of essential drugs, in collaboration with WHO and other agencies;

(f) Monitoring of the overall progress of the Initiative in countries that have adopted this strategy.

V. BAMAKO INITIATIVE INTERREGIONAL PROGRAMME

29. To date, a total of 17 countries in sub-Saharan Africa, in addition to Peru and the Sudan, have received specific allocations from the interregional programme for preparatory action. This support consisted mainly of specific studies of various aspects of health care delivery; initial training of national, district and local staff; the preparation of training manuals and diagnostic/treatment manuals; and start-up activities in limited geographical areas. Support to other countries, such as Zambia, has been provided through consultancy services rather than direct allocations.

30. Of the original countries earmarked for specific allocations (E/ICEF/1989/P/L.26), Mali, Mauritania and Zaire received full allocations, while Ethiopia, Ghana and the United Republic of Tanzania received part of the support envisaged. Only in Burkina Faso did action fail to materialize, mainly because of constraints affecting the transition from the essential drugs programme to the broader Bamako Initiative strategy.

31. At the end of 1990, the status of the $12.5 million approved by the Executive Board in 1988 and 1989 was as follows:

	Amount (Thousands of United States dollars)
Specific country allocations:	
Benin	400
Burundi	208
Cameroon	260
Congo	42
Equatorial Guinea	44
Ethiopia	330
Ghana	2 000
Kenya	200
Liberia	60
Mali	300
Mauritania	400
Nigeria	600
Peru	250
Rwanda	150
Sao Tome and Principe	35
Sierra Leone	600
Sudan	200
United Republic of Tanzania	60
Zaire	400
Subtotal	6 539
Interregional support	2 817
Funds available for 1991 action	3 144
Total	12 500

VI. RECOMMENDATION

32. The Executive Director recommends that the Executive Board approve special support for continued acceleration in the implementation of the Bamako Initiative and in order to continue assessing and supporting vital elements of concern for the period 1992-1994 in the amount of $9 million from general resources, subject to the availability of funds.

Breakdown of estimated expenditure
(In thousands of United States dollars)

Programme component	1992	1993	1994	Total
Support to country development of preparatory action	800	700	600	2 100
Monitoring of the country health situation	100	100	100	300
Health services monitoring systems	200	200	200	600
Operations research	500	500	500	1 500
Interregional support	1 400	1 500	1 600	4 500
Total	3 000	3 000	3 000	9 000